

THE  
BOSTON MEDICAL AND SURGICAL JOURNAL.

NEW SERIES.]

THURSDAY, MARCH 3, 1870.

[VOL. V.—No. 9.]

Original Communications.

REDUCTION OF DISLOCATIONS.\*

By WM. WARREN GREENE, M.D., Professor of Surgery  
in the Medical School of Maine, &c. &c.

In the discussion of this subject I shall confine myself to the consideration of two main questions.

1st, What is the principal obstacle encountered in our efforts at reduction?

2d, What rules of procedure should guide us in the treatment of these injuries?

If an answer to the first question is sought for in the surgical text books of the day, it will be seen that *muscular resistance* is universally deemed to be the great hindrance to reduction, and upon this idea are based the various methods of treatment recommended by surgical writers, from Hippocrates down to the present time. It is true that some authors admit other subordinate agencies, and Gross, with a characteristic breadth of view, attaches much importance to the great ease with which luxations are occasionally reduced even in muscular subjects, and on the other hand to the great difficulty oftentimes experienced in relieving these deformities even after complete muscular relaxation has been produced by venesection, nauseants and anesthetics; and he argues that the catching of the head of the bone under the muscles and tendons, the small size of the aperture in the capsule through which it has escaped, and the interlocking of the various prominences and

\* MR. EDITOR.—Nearly two years ago I began the preparation of a paper upon the Reduction of Dislocations, which ill health prevented my finishing. This work was undertaken both from an inclination on my own part to place before the profession doctrines which I deem of great importance, and also in accordance with the often expressed wish of many of my pupils that I should put on record views which they have found so valuable after testing them in practice.

With returning health I find my disposition for the work revived, while my conviction of its importance has been deepened by additional reflection and experience.

I have, therefore, written this paper, which, imperfect as I know it to be in its treatment of the subject, having been prepared amidst the constant pressure of other labor, contains ideas that I feel sure are worthy of the careful attention of my professional brethren.

Portland, Oct. 25, 1869. W. W. G.  
VOL. V.—No. 9

depressions so common in the vicinity of articulations and so marked in certain localities, must occasionally prove serious obstacles to reduction. Still he does not, nor, so far as I know, do any of the systematic writers on surgery recognize these conditions as other than occasional and minor in their operation. I think conclusive evidence of professional opinion on this subject, at the present time, may be found in the last edition of Erichsen's Surgery, the American reprint of which Mr. Lea of Philadelphia has issued within four months past. This really excellent work, which in most respects is fairly up to the times, may be assumed to teach the modern views and practices of the great majority of surgeons; and in the chapter on Dislocations, under the head of Treatment, page 291, the author makes this plain and unqualified statement. "The great obstacle to reduction is the tonic contraction of the muscles inserted into or below the displaced bones, and the surgeon's efforts are chiefly directed to overcome this contraction."

As my own belief and corresponding practice is diametrically opposed to this statement, I will first state it, and then indicate the line of thought through which I was brought to my conclusions.

Since February, 1856, I have believed and taught, for the last nine years publicly, as my classes in Berkshire Medical College, the Medical School of Maine and the University of Michigan can testify:—

1st, That the main opposing force to the reduction of dislocations is the untorn portion of the capsular ligament.

2d, That in our efforts at reduction the primary object should be the relaxation of the untorn portion of this ligament, and that whatever mode of procedure accomplishes this with most facility is the best.

3d, That occasionally the small size or peculiar shape of the rent in the capsule, or, in peculiar conditions of the nervous system, muscular contractions, may constitute the major forces with which we have to deal; but that these cases are so extremely rare as not at all to invalidate the general rule.

I desire at this point to call attention to  
[Whole No. 2196]

the fact that these propositions are not restricted to special dislocations, either as regards locality or variety, but apply to this class of injuries generally.

When a student of medicine in 1852 I became acquainted with Dr. Reid's views, then just published, upon reduction of the upward and backward dislocation of the head of the femur by manipulation. In a conversation upon the subject with my venerable friend, the late Dr. Young B. Walker, of Waterford, Me., he informed me that he had repeatedly effected reduction by a similar procedure which he learned from his preceptor, Prof. Nathan Smith, whom he had seen practise it successfully. He also said that Dr. Smith's explanation of the success of the method, as well as his own, accorded with that of Dr. Reid in attributing it to muscular relaxation.

In the winter of 1854-5 it was my privilege to be under the instruction of that excellent surgeon and teacher, Prof. Moses Gunn, now of Rush Medical College, Chicago.

He taught at that time that in the several luxations of the head of the humerus, and in the upward and backward displacement of the *caput femoris*, the untorn portion of the capsule was the main obstacle to reduction, and so far as the hip was concerned, he demonstrated his theory before his class upon a cadaver, having the articulation entirely cleared of surrounding muscles. Professor Gunn took, and ably defended the same position, in a paper published in the *Peninsular Journal of Medicine* in September, 1858, also published in the *New York Journal of Medicine*, and in a subsequent article, in which a part of the first paper was reproduced, which appeared in the *Peninsular Journal* in May, 1855.

It will be observed that while Dr. Gunn applied the same principle to the several luxations of the shoulder as to the one of the hip above mentioned, and while he differed entirely from Smith and Reid in his explanation of the remarkable ease of reduction by manipulation, putting ligamentous tension in place of muscular contraction, he yet like them confined the application of the principle, in the coxo-femoral articulation, to the upward and backward luxation; and in reply to my question whether the other dislocations of this joint might not be treated upon the same theory, he said he thought not.

These were the sources and this the extent of my knowledge upon the subject of reduction by manipulation and the claim of untorn ligament for consideration when

I entered upon practice; nor have I from that time to this seen or heard anything further about the matter, outside of my own investigations, except the remarks of Prof. Busch in the Year Book of the Sydenham Society for 1863, in which he attributes the resistance in hip luxations to ligament instead of muscle. I should add, that while I have no knowledge of such fact from Prof. Gunn himself, I have been told by several students that he now extends the principle to the several coxo-femoral displacements.

I became firmly possessed with the idea that so important a principle as this had been shown to be in connection with certain luxations, must have a more general application, and within a few months after graduating I had a case of dislocation of the *caput femoris* forward and upward upon the pubis, that I reduced with my own hands without the aid of anesthetics.

A few weeks later I saw a backward and outward luxation of the elbow in a lady 40 years old. I directed extension to be made in the line which the forearm then occupied, being the ordinary angle of flexion seen in this injury; this was done by first one, then two and finally three men pulling upon a towel attached at the wrist, while counter extension was made upon the arm just above the elbow, but without avail, the patient being meantime profoundly etherized. I now directed the assistants to cease their efforts, and seizing the arm firmly just above the elbow with my left hand, and the forearm with my right, I flexed the limb, making at the same time slight extension and rotation, and the deformity was immediately relieved. I argued with myself that if the resistance was principally or entirely muscular the powerful extension was certainly sufficient to overcome it, and that at any rate its action upon the muscles simply, was greater than the subsequent *effectual* movements of the limbs made by my own hands. Soon after this, in conversation with Dr. Daniel Towne, of Lowell, he alluded to the case of a man killed by machinery, who with other injuries sustained a dislocation of the elbow. The Doctor was called to put the mangled remains in as decent condition as possible for burial, and among other things reduced the luxation, "and," said he, "it required as much force to set those bones as if he had been alive." He also assured me that he saw the body before *rigor mortis* occurred.

These several cases strengthened my suspicion that in all forms of dislocation ligament and not muscle was the offending agent, and in the following winter I im-

proved an opportunity to make such observations *post mortem* upon the articulations of the elbow, wrist and phalanges as convinced me of the truths embodied in the propositions already laid down.

In considering the relative importance of ligamentous and muscular resistance to reduction the following facts should be well pondered:—

1st. The shafts of the long bones are, as a rule, surrounded by groups of muscles quite as powerful in their combined action as are those that envelope their articulations.

2d. In fractures of the shaft, with displacement of its mobile fragments whose sharp and ragged ends are constantly provoking muscular spasm, which increases its own cause, the amount of "contraction" is at least equal to that resulting from the displacement of its smooth and rounded articular extremity, which occupies a fixed position.

3d. In the various fractures (not impacted) occurring in the arm, forearm, thigh and leg, the cases are very rare in which the surgeon is not able, with his own hands, to make sufficient extension for the relief of the deformity, thus overcoming, of course, muscular contraction, even without anesthetics, his main difficulty being to retain the fragments in proper apposition; while in dislocations, effective extension in the ordinary mode often requires the force of several men or of the compound pulleys.

4th. Profound anesthesia annuls muscular resistance. But while it allows the fragments of a fractured bone to be replaced with the utmost facility, it oftentimes fails to diminish in any appreciable degree the difficulty of reducing dislocations, the most powerful extending force, if applied in the ordinary manner, still being required.

5th. It frequently happens that dislocations occurring in strong men, where there is no evidence of extraordinary muscular injury, are reduced with great ease by the rules laid down in the books, without anesthetics, and when the muscles are seen and felt to be in a state of positive resistance.

It would seem that such considerations as these should long ago have taught surgeons that an opposing force so constant under the varying conditions of muscular activity and repose, and again occasionally found wanting where vigorous muscles are known to be in a state of resistance, must be ligamentous. But I apprehend that here, as in other departments of thought, progress has been hindered by that too preva-

lent habit of observation and reasoning by which selection is made of such evidence as seems to substantiate a theory, while facts which, viewed in the light of the theory, occupy equivocal or mysterious ground, are ignored or passed lightly by. The world is full of doctrines, both in and outside of Medicine and Surgery, that can claim only this kind of support.

Upon the theory that muscular contraction is the most powerful opposing force to reduction, a very large proportion of the difficult cases must remain unexplained. But upon the assumption that the untorn portion of the capsule is the principal agent with which we have to deal, everything becomes clear, even from a theoretical standpoint alone, the exceptional cases, as will be clearly seen, I trust, before I close, proving the rule; and when we add the positive demonstrations upon the cadaver, *stripped of its muscles*, that, excluding such cases as have already been and will hereafter be alluded to, and which are equally important as corroborating this view, untorn ligament does accurately and constantly determine the characteristic deformity of the various luxations, and that, before reduction can be effected, this *firm, dense, inelastic structure must either be torn through or relaxed*; and furthermore, that by the time-honored method of extension and counter-extension the laceration is necessarily completed before the deformity can be relieved, the proof would seem complete.

With the exception of two years, I have, since 1856, annually repeated these demonstrations in the dissecting-room, under the observation of private students and of members of the profession, and in ten successive courses of lectures have given the same illustrations more or less fully before my classes in the lecture-room.

Among many gentlemen who have kindly assisted me while pursuing these studies, I am especially indebted to my former pupils, Drs. E. B. Lyon of Palmer, Mass., F. K. Paddock of Pittsfield, Mass., Geo. E. Frothingham, Michigan University, and H. H. Kimball, Minneapolis, Minn., for valuable aid; also to Dr. H. S. Cheever, of the University of Michigan, who, while Demonstrator of Anatomy in that institution in 1867-68, very kindly afforded me extensive opportunities for experimentation. As I have already said, these observations have abundantly confirmed the truth of the propositions already laid down, and which in general terms answer the two questions under consideration. I shall now state, as briefly and concisely as possible, the points

of greatest interest, both pathological and therapeutical, in relation to the several articulations, as noticed upon the subject stripped of muscles.

*The Shoulder.*—In this articulation the three luxations downward, forward and backward are readily produced by dividing the corresponding portions of the capsule to an extent sufficient to admit of the passage of the head of the humerus through the opening, when it is found that if the scapula and chest are covered with canvass sufficiently tense to represent the tegumentary, fascial and muscular coverings in the antero-posterior varieties, the positions that the limb assumes on the living subject in the several forms of this injury are accurately produced; and that if the limb is carried in such a direction as to relax the undivided portion of the ligament, reduction is at once effected.

The proper mode of procedure for restoring the displaced *caput humeri* may be stated in very few words. Raise the arm to a horizontal position, whatever the position of the head of the bone; then, if the head be in the axilla, make extension with a slight rotatory motion directly outward. If there is any delay in reduction carry the arm slowly upward, continuing the extension, if necessary, until it attains a perpendicular position. If the luxation be primarily forward under the clavicle, the elbow, already pointing somewhat backward, is carried still farther backward, gentle extension being made as in the first instance, until the posterior ligamentous band is so far relaxed that the bone slides into place. If the anterior position is only secondary to an axillary displacement, then as, by the movement last described, the head glides into the axilla, the limb is to be carried upward, outward and forward a little, and the reduction to be completed as in case of primary dislocation downward. If the luxation be the very rare one posteriorly upon the border or dorsal surface of the scapula, then the elbow, now pointing somewhat forward, is to be carried still further forward and upward also, for the reason that to attain this position the head of the bone has passed *downward* as well as backward, and the proper route through which the displaced bone returns to its socket is the one it travelled in leaving it.

But I have been often asked why it is, if these views are correct, that in the common dislocation into the axilla reduction is so often effected with facility by the ordinary method of extension downward, using at the same time the arm as a lever over a

fulcrum of some sort placed in the axilla. The answer is easy. Without noticing at present the cases of *extraordinary* laxity of the capsule, of which I shall speak further on, it is to be remembered that the scapulo-humeral articulation is more prone to luxation than any other. With its shallow glenoid cavity, which is hardly a cavity at all, and its roomy lax capsule admitting of such a wide range of motion, the head escapes with great facility, the limb constantly assuming, within the limits of ordinary motion, positions in which the axis of the humerus points over the edge of the shallow cup in which its articulating extremity rests, when but little more force is requisite for the production of the displacement than that which will tear the ligament; and it is for the reason that the capsule is of such amplitude, and that the glenoid cavity is so small in diameter and lacks the bony ridge which so securely guards the head of the femur, that in this injury the abduction is oftentimes so slight, the arm hanging almost straight by the side; and these same conditions facilitate reduction. Yet it is true that, while as compared with other joints the amount of tension of the untorn capsule is small, requiring proportionally less relaxation, it nevertheless exists as the main opposing force, which must be annulled either by tearing or relaxation before reduction can take place. How, then, if it is not torn, is the requisite relaxation effected in the common procedure referred to? I answer, by the accommodation of the scapula to the surgeon's efforts. Were this bone immovable this method would be unavailing, unless sufficient force were used to complete the laceration of the ligament; but it is very mobile, and as the surgeon, putting his heel in the axilla, makes extension downward, the shoulder-blade guides forward upon the thorax, and as the extending force is continued, and the humerus used it may be as a lever over the axillary fulcrum, the posterior and upper border of the bone is tilted from the ribs, the glenoid cavity being turned in the opposite direction forwards and *inwards*, until by this *change of position* the tension of the ligament is so far relieved as to allow the head of the bone to return to its place. But while, for the reasons given, the old method often succeeds, it always involves *unnecessary* force, and oftentimes an amount that seriously injures the axillary vessels and nerves, and occasionally it fails altogether.

With the manipulations I have described, I believe the surgeon will never fail in a re-



cent dislocation; the force required is trivial, and as no injury is done to the parts, the danger of subsequent inflammation is much diminished.

*The Elbow.*—By dividing the posterior and lateral portions of the capsule surrounding this joint and flexing the limb, but little force is required to drive the heads of the radius and ulna into their ordinary position in the backward luxation on the living subject. It is then found that the anterior fibres of the ligament hold the forearm in the position which it ordinarily occupies in this accident. The outward and inward varieties of the backward luxation are obtained by dividing in addition the inner or outer portion of the anterior ligament, the inner to produce the outward and the outer to produce the inward form.

If the anterior and lateral ligaments are divided, leaving the posterior bands intact, after freeing the olecranon, the backward dislocation can be produced by forcibly extending the forearm upon the arm, at the same time pushing it upward. In this case the forearm, instead of being flexed more or less upon the arm, as in the common form of injury, remains extended, nor can it be flexed to any extent without completing the division of the ligament posteriorly.

In the first and common variety in which the anterior part of the capsule is untorn, reduction is effected by flexing the limb and making pressure upon the anterior surface of the forearm, near the elbow, while an assistant steadies the arm—the same indication, *i. e.* relaxation of the untorn ligament, is fulfilled by the ordinary plan of flexion over the surgeon's knee—but in the rare form of luxation in which the posterior portion of the capsule remains untorn, the forearm being extended upon the arm, and not admitting of flexion, reduction is accomplished by extending the limb still more, or if necessary, bending it a little backward, when with a little lateral or rotatory motion the deformity is readily relieved.

I have referred in another part of this paper to two cases of dislocation of the elbow, one in my own practice and another seen *post mortem* by a medical friend, both of which, and especially the latter, gave decided evidence to my mind that here, as elsewhere, we have to deal principally with untorn ligament.

I have since seen a case in the practice of the late Prof. Timothy Childs, of Pittsfield, Mass., in which the man's arm being caught in a belt, the forearm was badly lacerated, and the entire group of muscles

around the humerus, except a small portion of the triceps, were torn through, exposing the bone midway between the elbow and shoulder; the elbow joint was not exposed, but was dislocated backward and outward. At my suggestion it was undisturbed until after amputation at the shoulder, when we found that myself making the extension and Dr. Childs the counter-extension in the line which the forearm occupied, our united strength was insufficient to reduce it; but I at once effected reduction by the manipulation I have described. An examination revealed a considerable portion of the anterior ligament untorn. Unfortunately, the prejudices of friends would not allow us to retain the specimen. Such cases need no comment.

Of the unusual condition in which the ligamentous tension is posteriorly, I have seen two cases in the living subject; one in private practice, and one which was brought to my clinic in Michigan University, by Dr. Andrews, of Detroit, and examined with me by Prof. Armor. In both instances the limb was straight, and the malposition of the bones easily detected. In the first case I very readily rectified the displacement by bending the forearm backward a little, and making gentle extension, the patient being etherized.

In the second case the luxation had existed several weeks, and the patient declined interference.

*The Wrist.*—Antero-posterior dislocations of the carpus upon the bones of the forearm are produced by dividing corresponding portions of the investing ligaments, and forcing the bones into malposition. But the capsule is so lax and the articulating surface so small, that the tension is slight, and the reduction of this exceedingly rare displacement is effected with but little manipulation—a fact rather difficult to explain, I think, upon the old theory, when we reflect what powerful groups of muscles send their tendons below this articulation for insertion.

*Metacarpo-phalangeal Articulations.*—Luxations of these joints are, in a majority of cases, readily reduced by simple extension, for the reason in some cases that the capsule is entirely torn, in others that it is inordinately large, allowing of displacement without tension, so that in either the only resistance is muscular. But a minority of these cases have always been recognized as exceedingly and mysteriously difficult to manage. Every now and then a case is met with where the most powerful extending force compatible with the safety of the

member is necessary, and various contrivances have been instituted for the purpose of making the extension efficient. Even then it sometimes fails. An explanation of these cases is simply impossible upon the theory of muscular resistance; but an examination of these articulations stripped of everything but the capsules reveals the fact that untorn ligament determines, here as everywhere, the deformity, and constitutes the resistance, and the simple rule is here, as in all luxations, *relax the untorn ligament*. Prof. Crosby, senior, of Dartmouth College, many years ago described a method of reduction in these difficult cases by forcibly bending the phalanx backward upon the dorsum to a right angle with the metacarpal bone, when, by pressure with the thumb or fingers, the head of the phalanx is made to slide forward into its place. This manœuvre, which is usually effectual, owes its success to the fact that it relaxes tense ligament, but that it may prove efficient it is necessary that the capsule should be torn in a certain direction, while at the same time something depends upon the original size of the ligament, and it therefore happens occasionally, as has been the case in my own and the hands of several surgeons of my acquaintance, that this procedure fails, and it fails in these rare instances because in those particular cases it does not relax the offending fibres. There is a great difference in different individuals in the size of these articulating surfaces and of the investing capsule, the capacity of the latter often being much greater than is requisite for the ordinary range of motion. Bearing this in mind, suppose a dislocation of the metacarpo-phalangeal joint of the index finger, the base of the phalanx resting on the dorsal surface of the metacarpal bone. Now it may be that in reaching this position the bone has completely lacerated the capsule. If so, simple extension will suffice for reduction. If the bone has escaped through a rent in the dorsal portion of the capsule, leaving a portion of palmar ligament intact, this will of course be upon the stretch more or less, according to its length, and it is upon its length that the success of Prof. Crosby's method depends. If the untorn palmar portion of the ligament be long enough to admit of the movement practised in this method, reduction will be accomplished. If the tense fibres are too short for this, then the manipulation will fail, unless sufficient force is used to lacerate them. It is probable that this laceration often occurs when but a small portion of the capsule remains uninjured, as the lever power ap-

plied is very considerable. In this class of cases the better manipulation, because it constantly relaxes the palmar ligament, is, *flexion* of the finger upon the palm, at the same time making extension.

Again, it may be that the capsule is so roomy as to allow the head of the phalanx to rest upon the metacarpal covered in by the dorsal ligament, with or without rupture of the anterior portion. In this case, if simple extension does not readily overcome the difficulty, Prof. Crosby's method will. And yet again, in these different conditions of the antero-posterior ligaments, certain remaining fibres of the lateral ligaments may require some modification of the manipulation to relax them.

A patient examination of a large variety of subjects will convince any one of the importance of careful attention to these several points, and of studying thoroughly, in a difficult case, the locality and extent of ligamentous rupture, and the degree of tension of the remaining portion. This may be readily ascertained by determining in which directions the finger moves, passively, most easily. The distal end will be carried most readily away from the side where the rupture exists, and with proper attention to these conditions and manipulations, in accordance with them. I believe that in recent cases subcutaneous division as so often practised by some surgeons will never be necessary, unless possibly in some peculiarly shaped and small-sized aperture, which in this joint I can hardly conceive possible.

I once saw a case with Dr. Oliver Brewster, of Pittsfield, in which he had tried extension and Crosby's method without effect, and was about to tenotomize, as he told me he had done several times in other cases, when it was found that by varying the procedure so as to relax some lateral fibres, reduction was accomplished, and he afterward told me that he believed if he had to go over the ground of the former cases again he could dispense with the knife. Whether or not the knife be occasionally indispensable, it is important to notice the fact that, when used, so far as I know, no surgeon thinks of dividing *tendon*, but finds it sufficient to divide some *ligamentous* band; thus practically, whether consciously or not, admitting the truth, for this locality at least, of the first proposition stated in this paper.

*The Hip.*—In the luxations of this articulation, the questions under discussion receive most emphatic answer. I have already referred to Prof. Gunn's able teachings and decisive demonstrations, with re-

gard to the upward and backward displacements of the *caput femoris*. I have only to add that the dislocation forward upon the pubis and downward upon the thyroid foramen, and the various modifications of these, are produced with as much accuracy and fidelity as regards symptoms as are the luxations upon the *dorsum ilii*—the difference in operating being that we divide that portion of the capsule in the direction of the luxation, or in other words, opposite the point where the head of the femur is to rest. This fact is, however, to be borne in mind. With the varying capacity of the capsule in different subjects, I have often found it necessary to divide the ligament more extensively than is necessary to merely allow of the passage of the head of the bone, in order to produce these deformities in a well-marked degree, and sometimes in making the luxation downward to cut the upper part of the ligament directly opposite the opening made for the escaping caput; and in the pubic dislocation I have found a corresponding manœuvre sometimes necessary. It is not necessary in either instance to divide the anterior and stronger portion of the capsule. I do not, in fact, feel quite clear as to what portion of the ligament is constantly or generally torn, or I might better say how extensively it is usually torn in these luxations. That accomplished and renowned anatomist, Prof. C. L. Ford, my former teacher and present colleague, who yearly demonstrates to his classes the influence of the untorn, anterior part of the capsule in the iliac displacements, long ago called my attention to the importance of considering the great difference in strength between the anterior and other portions of the capsule; a fact noticed by the various anatomical writers. In 1864, when Dr. Lyon, of Palmer, Mass., then Demonstrator of Anatomy in Berkshire Medical College, was examining a hip joint in which I had cut away all the capsule except the anterior portion, he, after considerable effort, succeeded in throwing the head of the bone both upon pubis and thyroid foramen, producing the characteristic symptoms without injuring the anterior band.

In a compound dislocation forward examined *post mortem* by myself and the late Dr. Geo. Collins, the anterior and lower portion was untorn, as was also a band stretched above the neck, attached to the upper edge of the acetabulum. In a man who was killed by falling from a great height, and who, otherwise horribly mutilated, sustained a downward luxation, it was found by Dr. F. K. Paddock, of Pitts-

field, Mass., and myself, in company with several medical men, that the inner and anterior portion was intact; also that a band ran from the posterior part of the neck to the posterior lip of the acetabulum. All these facts make me a little uncertain, without further investigation, which I hope soon to give the subject, as to the exact locality and usual extent of ligamentous injury in the several varieties of this injury. This is an important field for study. But while I feel somewhat uncertain as to the usual condition of the anterior portion of the capsule in these injuries, I am none the less certain of the application of the general principles I am endeavoring to establish.

In reduction of the iliac displacements I have used Reid's manipulation, now familiar to all surgeons, with satisfaction, and it must be admitted that it relaxes the untorn portion of the capsule; but I have found Prof. Gunn's rule equally efficient, and, as being still simpler, I prefer it—that is, *adduct the limb still further and invert still more*, when with a little extension the head returns to its socket.

I have reduced the pubic and thyroid forms of luxation, with my own hands, in accordance with the following rules:—

In the pubic or upward and forward luxation, *abduct, evert and extend the limb, carrying it backward.*

In the dislocation downward upon the obturator foramen, *abduct and evert the limb generally, carrying it backward.* In some cases the ligamentous tension is such that the latter movement is unnecessary, and a forward movement, with strong abduction, is better. It will be noticed that these movements, as those in the luxations upon the *dorsum ilii* (by which I mean the dorsal and so-called ischiatic), carry the limb to the position it must necessarily have occupied before the head of the bone could escape; and a most significant fact is, that this direction is the only one in which the limb can be carried without extraordinary, or at least unnecessary force. The intermediate forms of luxation, if I may use the term, depending upon variations of the ordinary ligamentous laceration, are to be reduced by the same general rules, varied according to the position of the limb which indicates the portion of the capsule on the stretch, *it being always borne in mind that this determines the character of the deformity.*

*The Knee.*—Partial dislocations of this joint are sufficiently common without ligamentous laceration, as we see oftentimes

in the remarkably lax capsules of "hysterical knees"; and partial displacement may occur, the one condyle occupying the place of its fellow, with partial or complete rupture of ligament on one side. In these cases reduction is effected by extension, the leg being at the same time adducted or abducted upon the thigh—adducted if the condyles are thrown outward, and abducted if the reverse position obtains. Complete dislocations of the knee, however, are rare. Yet they do happen occasionally, and nowhere in the body do the views set forth in this paper find more forcible illustration than in these injuries. When we consider the powerful group of muscles whose tendons surround and find insertion below this joint, and the marked prominences and depressions pertaining to the articulation, it may certainly be claimed that in complete luxation of the condyles of the femur upon the tibia, the conditions for "muscular resistance" are fully present. And yet the fact has been, in my own cases and in all those of which I can find a record, that the reduction has been *remarkably easy*. I have had two cases in my own practice, and both were readily reduced with my own hands, the patients being etherized. In the first instance, so readily was replacement effected that I fully sympathized with my friend Dr. O. S. Root, of Pittsfield, Mass., who saw it with me, when he remarked that if he had thought it would "go in so easy" we would have studied the rare phenomenon a little more before attempting reduction. The second case was equally amenable to treatment. Now, how upon the old and common theory can these things be explained? If it be said that ruptured tendons might give a solution, it would be very difficult to reconcile this assumption with another remarkable feature of my own and other reported cases (and which has an important bearing upon the influence of complete laceration of capsule upon the reparative process), which is, that these cases recover with wonderful rapidity. My first case walked one quarter of a mile to my office, using only a cane, and with hardly a limp, in three weeks from the day of his injury; and this although he sustained a severe scalp wound and an amputation near the shoulder. The second case walked easily in four weeks.

But upon the ground that difficult reduction implies ligamentous tension, all becomes plain; for the articular surfaces are here expanded to such size in proportion to the laxity of their ligamentous invest-

ments, that *I have never found it possible upon the cadaver to produce a complete dislocation without entire division of the ligaments around the joint*, so that there is no untorn portion left to be put on the stretch in these accidents.

I have thus briefly and in general terms stated the results of my investigations upon this subject. Much remains to be done in detail in the critical study of the various dislocations in the light of the theory here advanced, and, I could hope, established; but while more minute knowledge shall render our work still more easy and certain, I am confident that an adoption of the general principles I have laid down will rob surgical practice of much that has been unpleasant and formidable. For myself I can say that, in a practice of fifteen years, in which it has been my lot, I think, to see a fair proportion of luxations, I have never failed, in a *recent dislocation*, with the patient etherized, to relieve the deformity without any aid except from counter-extension; and I am sure this has been from no unusual skill on my part, but simply due to the recognition of ligament instead of muscle as the agent with which I had to deal. I have been unusually fortunate in escaping those rare cases of small and peculiarly shaped rent in the capsule which, buttoning around the neck of the bone, sometimes necessarily embarrasses the surgeon. In the only case where I diagnosed such a condition—a backward and upward dislocation of the head of the femur—I somewhat timidly and very cautiously used the femur as a lever, forcibly flexing and extending the thigh, thus endeavoring to enlarge the opening, which I apparently accomplished, as afterward the bone returned readily to its socket upon carrying the limb across the sound one, extending and inverting it. I say timidly, for I am not sure whether sometimes the neck of the femur might not yield before the capsule.

In addition to my own experience, I am happy to know that my pupils everywhere, so far as heard from, testify to the value of these doctrines as they test them in practice.

In conclusion, I desire to remind the reader that in this discussion neither is muscular resistance ignored on the one hand, nor on the other is it claimed that untorn ligament is always present, or, if so, is invariably an obstacle to reduction. On the contrary, for the muscles, it is admitted that they may operate with as much force—no more—in opposing the reduction

of a dislocation as in the adjustment of a fracture, and in very rare cases, as in tetanic conditions, this may be extreme; but it is claimed that as an almost universal rule the surgeon's personal efforts are sufficient to overcome this muscular contraction, while anaesthesia practically abolishes it.

Again, it is admitted that very often the ligaments are entirely torn through, leaving nothing but muscles to encounter; and again, that the capsule in rare cases is so lax as to admit of complete displacement without tension of the untorn portion, or even without any rupture at all. This is important to remember in studying this subject upon the dead body. I have seen subjects upon which it was hardly possible to produce a complete luxation of any joint in the body without entire severance of the capsule, so short and tense were the ligaments in proportion to the unusually large articular surfaces; and again, I have found the capsule of the hip, even, so large and roomy that in one instance, much to my surprise, I was unable to demonstrate the position of the limb and the resistance of the untorn ligament in the upward and backward dislocation. In this instance, but for the *teres* ligament, I think spontaneous luxation would have been possible during life without rupture of the capsule at all. But it is affirmed that when the capsule is entirely destroyed or is extraordinarily loose, there is no *great* opposing force to overcome, and that the fact of easy reduction by extension in the position which the limb occupies is proof that one or the other of these conditions exists; and it is further claimed that where any great amount of resistance is present, with the exceptions already made, it is ligamentous, and that before reduction can be effected the offending fibres must either be ruptured or relaxed. The laceration can be accomplished by brute force only, while the requisite relaxation can be attained by intelligent manipulation.

Within a few days after the completion of the foregoing paper, in October last, I received the excellent and classical work on "The Hip," recently published by Prof. Henry J. Bigelow, of Boston, which I have read with pleasure and profit. It came early enough to give me the pleasant opportunity of giving him full credit for his views in a discussion upon this subject in the Cumberland County Medical Society, and I have until now hesitated whether or not to re-write some portions of my paper. But, upon consideration, I prefer to publish

Vol. V—No. 2A

the article as originally prepared. I am most happy to learn, what I regret not to have known before, that this accomplished surgeon has for several years recognized and taught the doctrine of ligamentous resistance as applying to the several dislocations of this joint—I shall rejoice to learn that he extends its application to the other articulations—and he maintains that it is the anterior portion of the capsule, with its strong ilio-femoral reinforcement, which he describes as a distinct structure under the name of the Y ligament; that is, the constant factor determining the position of the limb and opposing the reduction in the various forms of luxation. I have already alluded to my indebtedness to Prof. Ford for suggestions upon this point, and to doubts that had arisen in my mind in connection with my own and Dr. Lyon's observations, and I have therefore been especially interested in this portion of Prof. Bigelow's book; but while it is undoubtedly proven that the ilio-femoral ligament may accomplish all this, I do not feel quite sure that it is so constantly the offending agent to the exclusion of other portions of the capsule, as the author maintains. If so, I do not see clearly how the pubic and thyroid dislocations were so easily reduced in my own cases by the manipulations I have described. Nor is the anterior portion of the capsule always so dense and strong. It is only yesterday that I found the ilio-femoral bands almost entirely wanting. The subject was a female, in a good state of preservation, upon which I was demonstrating the "ligamentous theory" before the class of the Portland School for Medical Instruction, and having cut away the posterior and upper portion of the capsule, I found myself able with my own strength, an assistant making counter-extension, to tear the anterior portion by simple extension. This was witnessed not only by the class, but by Drs. Foster and Weeks of this city, Bates of Yarmouth, Hall of Cumberland, and other members of the profession. This of course was an exceptional case, but, together with the reasons already given, makes me somewhat doubtful whether the "Y ligament" may not be more frequently torn than Dr. Bigelow supposes. Upon this question hinges another, as to the propriety of the general rule for flexing the thigh in all cases. But I have no disposition to discuss these points without farther observations, and can only hope that the attention of the profession will be so drawn to them that they may be speedily settled beyond question.



Upon the enlargement of the capsular opening by circumcision, Prof. B.'s experiments seem conclusive, and have given me great relief; for it seems well established that in a healthy bone the capsule will yield without danger of fracture.

January 27, 1870.

W. W. G.

## Selected Papers.

### PREMATURE DELIVERY AS A PROPHYLACTIC RESOURCE IN MIDWIFERY.

[We select the following passages from a valuable paper in the *New York Medical Journal*, by Dr. T. Gaillard Thomas.]

The practice of inducing premature labor, unlike that of abortion, is of very recent date. Denman informs us that in the year 1756 a congress of physicians was held in London for the purpose of discussing the advantages of the procedure. It was approved of, and since that time its adoption has steadily though slowly extended.

The following list presents the morbid states for which I should consider the operation indicated:—

1. Deformity of the pelvis.
2. Placenta prævia.
3. Aggravated uræmia.
4. Excessive vomiting.
5. Placental apnea.
6. Commencing epithelioma.
7. Death of child and consequent septicæmia.
8. Threatened death of child.
9. Approaching death of mother.
10. Amniotic dropsy.
11. Previous rupture of uterus or performance of the Cæsarean section.
12. Excessive accidental hæmorrhage.
13. Previous difficulty in deliveries of large children, or of children with ossified sutures.
14. Tumors obstructing the pelvis.

From this enumeration of indications for the induction of premature delivery, I have intentionally excluded a number which call for abortion, but not for the procedure which now engages our attention. I have likewise, for the purpose of avoiding prolixity and a spurious show of completeness, omitted the enumeration of certain rare conditions which might call for it, but would in all probability never do so. \* \* \*

*Placenta prævia.*—No one who has had experience with this form of complicated labor, will feel disposed to undervalue or cast aside any remedy which is offered for

the rescue of patients presenting its premonitory symptoms. So serious are its results that, although it occurs not oftener than once in five hundred cases, which is the proportion computed as correct by some authors, it exerts a marked influence upon the statistics of obstetrics. According to the calculation of Sir James Simpson, based upon the analysis of three hundred and ninety-nine cases, one-third of the mothers and over one-half of the children are supposed to have been lost. The reasons for this great mortality are probably the following:—

1. The dilatation of the cervix for the passage of the child, unavoidably exposes both mother and infant to great danger from placental detachment and hæmorrhage.

2. Repeated hæmorrhages occurring during the ninth month; as the os internum dilates under the influence of painless uterine contractions, which then occur, the woman at the time of labor is usually exsanguinated, exhausted, and depressed both physically and mentally.

3. Profuse flooding generally occurring with the commencement of labor, the medical attendant is often not at hand, and reaches his patient only after a serious loss of blood has occurred.

Fortunately this condition is usually announced during the last months of utero-gestation by premonitory signs of a reliable character, and thus we may empty the uterus before the vital forces of both mother and child are exhausted by hæmorrhages, the results of repeated detachments of the placenta. My conviction is that, in every case of declared placenta prævia, premature delivery should be induced. What objections can be urged against it, other than that a child of less than nine months of intra-uterine life does not have as good a prospect of life as one which has arrived at full term? In the case which we are considering, even this falls to the ground, for an eight-months child out of the uterus, and depending upon pulmonary respiration, has a brighter prospect for life than one in that cavity depending for aëration of its blood upon a crippled and bleeding placenta. For the mother, how incomparably greater the safety which attends an emptied and contracted uterus! By inducing delivery during the ninth month of pregnancy, we should be dealing with a woman who is not exhausted by repeated hæmorrhages; we would be in attendance at the moment of cervical dilatation, and consequently the moment of danger; and we would be able by hydrostatic pressure to control hæmor-



rhage in great degree, while at the same time dilatation of the cervix, which constitutes the period of maximum danger, may be rapidly accomplished.

With these considerations before me, and with a certain amount of experience to support them, I cannot resist the conviction that, when premature delivery becomes the recognized and universal practice for placenta prævia, the statistics of Dr. Simpson will be replaced by others of a far more satisfactory kind.

I have induced premature delivery for placenta prævia four times, and, as the subject appears to me to be of paramount importance, I risk the danger of wearying my audience by detailing all the cases:—

CASE I.—Mrs. W., aged 26, primipara, in good health, was suddenly taken with hemorrhage three weeks before full term. She sent for me in great haste, but, being occupied, I was unable to go to her, and she was seen for me by my friend, Dr. Reynolds. He discovered that she had lost a few ounces of blood, but that the flow had ceased. Three days afterward she was again affected in the same way, the flow ceasing spontaneously. About a week after this, she was again taken during the night with a flow, which was so profuse as to result in partial syncope when she endeavored to walk across the room. I saw her early the next morning, found her flowing slightly, and, upon vaginal examination, succeeded in touching the edge of the placenta through the os, which was dilated to the size of a ten-cent piece. Later in the day, Drs. Metcalfe and Reynolds saw her, and agreed in the propriety of premature delivery. In accordance with this consultation, at 7 P. M. I introduced into the cervix, with considerable difficulty, and by the employment of some force, the smallest of Barnes's dilators. This in twenty minutes was followed by the next larger dilator, and in an hour by the largest. Dilatation was rapidly accomplished, but, instead of removing the largest bag, I left it in the cervix until 10 o'clock that night. Expulsive pains coming on at that time, I removed it, when the head rapidly engaged, and before morning Mrs. W. was safely delivered of a living girl. The placenta followed rapidly, and both mother and child did well.

In this case, although hemorrhage continued slightly throughout the labor, it was never sufficiently profuse to endanger the lives of either mother or child. The implantation of the placenta being lateral, diminution of the flow occurred as the head advanced, and made firm pressure against the bleeding surface.

CASE II.—Mrs. D., a lady over 40 years of age, whose last pregnancy had been completed fourteen years previously, was placed under my care by Dr. Metcalfe. She was an excessively nervous and hysterical woman, but in good health. About three weeks before full term she was taken with hemorrhages, which lasted for very short periods, recurred at intervals of four or five days, came on without assignable cause, and ceased without remedies. The cervix was not dilated, and no physical signs of placenta prævia could be detected either by vaginal touch or auscultation. Dr. Metcalfe saw her in consultation, and, as all the rational signs of placenta prævia were present, and our patient was suffering from the repeated losses, and was becoming extremely nervous and apprehensive, we concluded to bring on premature delivery. Accordingly, at 11 A. M. I introduced a large sponge-tent into the cervix, and at 3 or 4 P. M. removed it, and succeeded in inserting Barnes's smallest dilator. At 9 that night the cervix was fully dilated at the expense of very slight hemorrhage, and Dr. Metcalfe then being present, I removed the bag, intending to leave the case to Nature, provided no flow occurred. Previously, during the evening, upon changing the bags, I had distinctly touched the head as the presenting part, but now, to my surprise, I found that the bag impinging on this part had caused the child to revolve in the liquor amnii, and that the breech was now within the os.

We decided under these circumstances to deliver at once. The patient being put under the influence of ether, I drew down the legs and delivered a living female child. The placenta followed in fifteen minutes, and both patients did well, the child rapidly recovering from an injury to one of its legs, received during delivery.

In this case, the placenta was very nearly centrally attached. At one side of the os internum, a space of only two fingers' breadth was free. Through this, digital examinations were made, and the hand pushed to seize the feet. The first stage being accomplished by means of the hydrostatic dilators, no hemorrhage attended it; but, without this means having been employed, it is highly probable that profuse and dangerous flooding would have occurred.

CASE III.—Mrs. P., a multipara, aged 38, had advanced, without any unfavorable symptoms, to the middle of the ninth month of pregnancy. At this period, while sitting, at 9 P. M., in her parlor, engaged in

some light needle-work and in conversation, she suddenly felt a free flow of blood pouring away from the vagina. In a few moments she became very much exhausted, and was lifted up by her husband and carried upstairs to bed. I saw her within an hour after this, and found her still losing blood to a slight extent. Her pulse was very rapid and weak, and her face extremely pallid. It was estimated that about one quart of blood had passed, though this was of course uncertain.

As the flow had ceased after I had kept the patient quiet for an hour, I left the house, promising an early visit in the morning. Upon this visit I found her doing well, though somewhat exhausted. Feeling satisfied, from the great amount of flow, and the fact of its having occurred without any exciting cause, that placenta prævia existed, I now explained the state of affairs to my patient's husband, and requested Dr. Metcalfe to see her in consultation. He agreed with me that the probability of the safety of both mother and child would be greatly increased by at once inducing premature delivery, and at 9 that night I set about accomplishing it. At 9.30 exactly, in the presence of Dr. Metcalfe, I introduced into the cervix the smallest size of Barnes's dilators, and at 10.30 the os was fully dilated. So long as the bag was retained in the cervix, no hæmorrhage occurred, but on the instant of its removal a flow took place. Under these circumstances it was thought best to deliver at once. The patient being put under the influence of chloroform, I performed bimanual version, and with great ease delivered a living child. The placenta soon followed, and mother and child recovered without an unfavorable symptom.

In this case, delivery was accomplished in one and a half hours from the commencement of the effort, and the process was inaugurated just twenty-four hours after the development of the first symptom of danger. The flow which constituted this symptom was so sudden and alarming that we thought that great danger would attend delay, uncompensated for by any corresponding advantage. After full dilatation and removal of the dilator, Dr. Metcalfe examined and found a very large piece of placenta hanging out of the os uteri, and thus the diagnosis was proved to have been correct.

CASE IV.—I was called on the 14th of November, by Dr. Keeney, to see with him Mrs. R., a multipara, aged 23 years, who was nearly at the end of the seventh month of pregnancy. About one week before our

visit she had been suddenly seized with quite a profuse hæmorrhage, which had rapidly diminished, but never completely disappeared. The nature of the flow, which occurred by sudden gushes, and in great profusion, led us to the conclusion that it was due to placenta prævia, but as the period was not favorable to the viability of the child, we determined to avoid interference until the eighth month, if possible. The patient was accordingly kept perfectly quiet in bed, and all effort avoided. For two and a half weeks this plan appeared to succeed, and we had strong hopes of reaching a period when both child and mother might be rescued by premature delivery. When the seventh month and one week of the eighth had passed, the flow returned, and continued so steadily that, to our regret, we were forced to empty the uterus in the interest of the child, who was evidently becoming much enfeebled by gradual placental detachment, and of the mother, who likewise felt the loss of blood very perceptibly.

At this period Dr. Keeney and I met at the patient's house at 8.30 P. M. At twenty minutes before 9 I introduced Barnes's smallest dilator. At ten minutes after 9 the os was fully dilated, and I, introducing my hand, readily delivered a living child by version. The child was evidently very feeble, and, although at once wrapped in cotton and surrounded by an atmosphere heated to 95°, it lived only about nine or ten hours.

In this case, as soon as the os was fully dilated, we could distinctly feel the placenta, and as I passed up my hand I found that it was centrally attached. It is the only case in which I have met with complete placenta prævia. The mother recovered without an unfavorable symptom. \*\*

INFLUENZA.—The West-end of London has been visited with severe influenza during the last fortnight. It usually begins quite suddenly with pain in the throat and ears, followed by shivering, *malaise*, constriction of the chest, sneezing, and utter prostration. The temperature goes up to 102° the first night, and there is some tendency to lightheadedness. Bed, lemonade, and beef-tea, with an aperient pill and ammonia draught, the first day; next morning a five-grain dose of quinine, and half a pint of champagne at night, form the best way of dealing with this unpleasant visitor—*tuto, cito, et jucunde*.—*Med. Times & Gazette*.

## Reports of Medical Societies.

BOSTON SOCIETY FOR MEDICAL IMPROVEMENT.  
CHARLES D. HOMANS, M.D., SECRETARY.

JAN. 10th, 1870.—*Lupus treated by Galvano-Cautic.*—Dr. WHITE showed a section of lupus under the microscope, and also a patient who had the disease, and had been galvano-cauterized. The following is the account of the case.

"Mr. L., aged 38 years, is paralytic; constitution broken down; one year ago, disease appeared on top of left shoulder as a reddish lump, which in a month broke down at one point, and since then the ulceration has been spreading towards the circumference, healing in the centre.

Nov. 11th, he was treated by cautery, with the nitrate of silver, and this was repeated three times, but the tissues surrounding the parts cauterized broke down, the man having poor food and bad hygienic surroundings.

Dec. 22d, the galvano-caustic was applied, and again Jan. 1st, each time with great benefit, healthy granulations rapidly filling up the parts destroyed by ulceration.

Dr. WHITE had treated two other cases in a similar way, as follows. Barbara W., aged 20 years; the disease began at 3 years of age on her face, destroying one eye eleven years ago, and soon after the nose; five years ago it appeared on the buttock. Now, prominence of nose entirely absent; mouth reduced to a slit of half an inch in length, bounded by firm cicatricial tissue; skin of face generally changed into superficial scar tissue; some fresh ulceration about the mouth; left buttock occupied by an encrusted border of serpiginous herpes, forming a complete circle eight inches in diameter. Nitrate of silver was applied several times, the stick being, in some places, pushed to the extent of an inch into the boggy tissues. Subsequently, the galvano-caustic was used twice, causing healthy granulations and rapid healing, while the part in which the use of the nitrate was continued made slow progress. Now, is completely healed."

"R. C. H., 27 years old. Disease first appeared on the hip five or six years ago, and two or three years ago on the scalp.

August, the forehead and scalp, largely occupied by the disease, were covered with crusts, beneath which the integument was easily ploughed up by a stick of nitrate of silver; beyond the limit of surface, disease in all directions; over the right trochanter

was a patch of the disease three inches in diameter. All these parts were touched repeatedly and thoroughly with the solid nitrate for two months, at intervals of a week, but they healed very slowly.

Oct. 21st, galvano-caustic was applied, and three or four times subsequently, at intervals of three days, to all the affected parts. Healthy granulations began to form after the second cauterization, and on Nov. 6th the disease was wholly subdued. Acute desquamative nephritis, with universal anasarca, suddenly appeared, although the health had been good previously, which lasted two weeks."

Dr. WHITE said patients think the subsequent pain much less and of shorter duration than when lunar caustic is used; its action can be limited, though more active than nitr. arg. He described the battery and the mode of using it, and spoke of its advantages. To Dr. LYMAN, he said that in superficial lupus the acid nitr. of mercury was sometimes better than arg. nitr., but not so good if the disease extends deep.

Dr. HOPKES said the quickness with which a galvanic cautery was got ready for action made its use very advantageous in surgery. Since the Massachusetts General Hospital had possessed this apparatus it had been in frequent requisition. He had himself used it in a variety of cases, and was much pleased with its efficacy and convenience. The uniform degree of heat, which persists so long as the battery works, permits the application of the actual cautery in many instances where it would be impossible if a charcoal furnace, spirit lamp, or Brunsen's burner were depended on. The wire can be inserted into a hemorrhoid or nevus, for example, and kept there cauterizing as long as is desirable; one otherwise heated loses its caloric so quickly on contact with the tissues that its action is but slight. By means of the galvanic cautery, Dr. HODGES had treated and cured, with a minimum of deformity, a nevus which involved the gum and entire thickness of the upper lip and cheek, as well as the ala and tip of the nose. The disease was so extensive and irregular in shape that it would be difficult to have conceived its treatment possible by ligature, excision, or any mode of cauterization other than that which was adopted. Four sittings, at intervals of about three weeks, were required.

JAN. 10th.—*Necrosis of Radius; Hemorrhage; Amputation.*—Dr. LYMAN reported the case.

The patient, aged 55, had an acute attack of osteitis in February, 1868, without

known cause. He was first seen by Dr. Lyman in May, 1868, at which time free openings were made over the radius and carpus to evacuate collections of pus, and some pieces removed from the latter. Firm anchylosis of the carpus with the adjoining bones ensued, and entire loss of movement in the hand and fingers.

October, 1869, the sequestrum from the radius began to loosen, and it was proposed soon to attempt its removal. The patient returned to his home, some distance in the country, and, Dec. 17th, profuse sudden hæmorrhage occurred, and again on the 18th, reducing him very much. He was seen by Dr. Lyman on the following day. As the origin of the hæmorrhage was uncertain, the whole forearm being infiltrated and oedematous, and as the usefulness of the hand was already destroyed irrecoverably, it was decided, in consultation with Dr. Cheever, that amputation was preferable to ligature of the brachial. This was done, by Dr. Lyman, Dec. 20th. On examination, it was found that a sharp spiculum from the sequestrum, projecting from the lower third of the bone, had divided the radial artery. Hæmorrhage from such a cause in necrosis must be a very rare accident.

JAN. 24th.—*Recent Views of Tubercle.*—

Dr. ELLIS, in reference to Dr. Jackson's paper, read at the last meeting, said Niemeyer is obscure; he does not say what tubercle is, probably taking it for granted that the modern definition is sufficiently well known; he does not make a distinction between well-established facts and theories founded on ideas. In croupal, catarrhal pneumonia and tubercle he describes what cannot be seen without a proper preparation of the product for the microscope; by means of this instrument the vast majority of caseous masses are shown to be something else than tubercle, and are found in cancer and various other cases.

Gelatiniform material is very rarely seen in connection with what has been called "infiltrated tubercle," now "chronic pneumonia." The statement that pneumonia affects only the substance of the lungs is not correct. To deny inherited tendency to tubercle is not correct; certain persons do inherit a tendency to degeneration of the lungs. The older writers spoke of the inflammatory origin of tubercle, but their ideas were based on theory, the present ones on facts derived from microscopic observation; formations formerly called tubercular are now well recognized as products of inflammation.

To Dr. BETHUNE, Dr. ELLIS said tubercle in the fresh state and the pneumonic product would to the naked eye be very different—the one translucent, the other opaque; but when degenerated they could not easily be distinguished.

Dr. JACKSON repeated what he had said in his communication to the Society, that tubercle, as heretofore understood, and in all its forms, is, he believes, allied to inflammation, but it is only an alliance; and he again drew a parallel between Niemeyer's croupal and catarrhal pneumonia, and showed how widely they differed from each other in their gross character and in their tendencies. He referred to his "acute miliary tuberculosis," in which the lungs are crowded with small granulations from apex to base, as seen often in tubercular meningitis, and in cases that have passed during life for typhoid fever; and he asked Dr. Ellis if he had ever seen this form of disease as a complication in an ordinary case of phthisis?

Dr. Ellis answered that he had seen miliary granulations in the so-called cases of common phthisis, and that Niemeyer as well as others who insist upon the pneumonic character of the latter, state that miliary granulations generally make their appearance during the course or towards the close of this common disease. These translucent, widely disseminated granulations are true tubercle, and are quite rare as a distinct disease when compared with that usually called phthisis.

JAN. 24th.—*Erectile Tumor following a Blow; Operation; Secondary Hæmorrhage; Death.*—Dr. CABOT reported the case.

J. H., farmer, aged 53, entered Massachusetts General Hospital Nov. 12th, 1869, with a tumor the size of a small orange, just above inner malleolus of left foot. Tumor had a hard base. The upper part was elastic. It had existed little more than a year, coming on after a blow from a crowbar. Had been told by his country surgeons that he must lose the foot.

Operation on the 13th.—An incision about three inches in length was made over the tumor. The upper part of it was a sac filled with blood. The hard base was a sort of erectile tissue, resembling organized blood clot. Sutures were passed through the flaps but not tied—a sponge placed over the wound and snugly bandaged, to check the oozing, which was quite free. The stitches were tied in the afternoon, and compression continued.

On the second day after the operation a little slough appeared in the centre of the

flap; stitches were removed, and yeast poultice applied.

On the third day a suspicious redness about the wound.

On the fifth day well-marked erysipelas over foot and ankle; wound quite sloughy; line of lymphatics running up the leg; a vein divided by slough; bled quite freely at morning dressing.

On the 19th, the sixth day after the operation, bled again quite freely; fluctuation over ankle, and on dorsum of foot. He was etherized, and incisions made, which bled quite freely. The original wound and incisions were touched with ferri perchlor., stuffed with dry lint and firmly bandaged.

On the 27th (fourteenth day after operation) had a well-marked rigor; foot discharging freely; delirium well-marked.

Chills continued at intervals until the 30th; he was ordered two-thirds of a minim of a saturated solution of carbolic acid ter die, which was gradually increased to  $\pi j.$  of the solution four times a day. Marked improvement followed, chills ceased almost entirely, the delirium disappeared, and appetite returned.

On the 4th of December the bleeding from the foot returned, and continued at intervals until his death.

On the 8th he complained of severe pain in left chest.

On the 9th (the twenty-fifth day after the operation) the foot bled quite freely; he was etherized, and the incision over ankle enlarged; the foot was found to be generally undermined; the tibia was denuded and apparently perforated. Amputation was declined; the wounds were stuffed with sponges soaked in tinct. ferri perchlor. The patient became quite pulseless during the operation. Stimulants were given freely during the afternoon, but he died about 10, P. M.

An autopsy by Dr. John Homans showed a circumscribed pleurisy of left side. No other lesion.

JAN. 24th.—*Puerperal Convulsions at the Seventh Month; Successful Induction of Premature Labor.*—Dr. SINCLAIR reported the case, to which he was called in consultation.

A primipara, 23 years old, had convulsions somewhat alleviated by the inhalation of chloroform, but still continuing when first seen by Dr. S., ten or twelve hours after the convulsions began. The os uteri would not admit the index finger, and the entrance of the vagina was rigid; the urine had been found to be albuminous, and

there had been none at all for the twenty-four hours before the onset of the convulsions. Labor was brought about under chloroform, by gradually dilating the os by introducing one finger after another, till the hand could be passed in. Dr. S. was struck by the clearness with which the inner os could be made out, and the distance between it and the outer os. Dilatation occupied one hour and a half; the membranes were ruptured by the hand in the uterus; the head presented, but a foot was found, the child turned and born alive; ergot was given just before the exit and good contraction followed. The only uterine contraction before the birth was on the hand in the womb, requiring deep chloroformization to overcome it. The mother had a few convulsions after her confinement, but has since done well.

In these cases it seems necessary that dilatation should be done very gradually, and in the course of fifteen or twenty minutes the parts seem to give way all at once.

Dr. LYMAN said Dr. Sinclair's statement as to the condition of the os was interesting in connection with the opinion of Cazeaux that the internal os does not disappear till the last month of pregnancy, the external os and neck becoming very soft before, and giving the impression to the examiner that they have disappeared.

Dr. PARKS said first rate observers differ in this regard; some writers say the cervix becomes so soft as to yield to the finger and give an impression that it has shortened, when this is not the fact; others think the uterine neck gradually shortens throughout pregnancy.

ANOSMIA.—Dr. Ogle, in his paper on "Anosmia," at the Royal Medical and Chirurgical Society, on Jan. 25th, observed that anosmia is frequently the accompaniment of aphasia, and argued that this was because of the proximity of the so-called external root of the olfactory nerve to the part of the brain usually affected in aphasia. Dr. Webster said anosmia evidently depended on injuries, &c., to the brain, and Mr. Gascoyen mentioned two cases where the soft palate adhered to the pharynx, and both patients were without the sense of smell; and another where a patient lost the bones of her nose, and now had neither taste nor smell.—*Dublin Med. Press and Circular.*



## Medical and Surgical Journal.

BOSTON: THURSDAY, MARCH 3, 1870.

### A BILL TO REPEAL THE CHARTER OF THE MED. SOCIETY OF THE DIST. OF COLUMBIA.

We have received a copy of the *National Republican* newspaper for February 12th, containing the report of the Congressional Committee on the District of Columbia, upon the order of the Senate to consider the expediency of repealing the charter of the Medical Society of the District; also a copy of the *National Republican* for February 17th, containing strictures on the said report. The memorials of the Medical Society of the District of Columbia and of the National Medical Society of the District of Columbia, printed in our issue of February 17th, have placed the leading points of the two contending parties before our readers, who have a right to be informed upon the question in dispute, inasmuch as the District of Columbia is, in a special sense, national domain. We propose to extract from the report of the committee, whose chairman is one of the Senators from this State—Mr. Sumner—such additional facts as threw further light on the question under discussion, keeping our political sympathies as much as possible in abeyance, since a medical journal is no place for their display. In order, however, that the reader may make due allowance for any bias which may rest on our mind, we deem it but fair to state our position at the outset, although it may suit the views of no one but the writer. We hold that the time is past for political or civil disabilities, on the ground of color or race; but that questions of social juxtaposition should be allowed to work themselves out on the basis of Christian brotherhood.

The chartered body is the "Medical Society of the District of Columbia." "It has," say the Committee of Congress, "power to hold property, which according to the tenor of this act, is to be applied 'to such purposes as they may adjudge most conducive to the promoting and disseminating medical and surgical knowledge, and for no other purpose whatever.' Such was the declared object of the society. Its ob-

ject was science, and no other purpose whatever."

Among other provisions occurs the following:—

"That it shall be lawful for the said medical society, or any number of them attending, not less than seven, to elect by ballot five persons, residents of the District of Columbia, whose duty it shall be to grant licenses to such medical and chirurgical gentlemen as they may, upon a full examination, judge qualified to practise the medical and chirurgical arts, or as may produce a diploma from some respectable medical college or society, each person so obtaining a certificate to pay a sum not exceeding ten dollars, to be fixed or provided by the society."

Certain colored physicians offered themselves for examination under this regulation, passed and were licensed to practise medicine in the District.

The Committee go on to say:—

"Besides this charter is what is entitled a 'constitution,' adopted by the society, where will be found further details, expressed in articles.

"By one of these it is declared in substantial harmony with the charter, as follows:—

"The object of this society shall be the granting of licenses agreeably to the provisions of the charter, and the consideration and promotion of all subjects connected with medicine, and the collateral branches of the science."

"Thus again is the society dedicated to medical science, and constituted an educational institution.

"By another article it is declared:—

"Candidates for membership shall be duly proposed to the Medical Society, and be recommended by the board of examiners, and may be balloted for at the meeting next after their proposal, when it shall require the concurrence of two-thirds of the members present for their admission, and every member so elected shall have previously paid to the treasurer of the society an admission fee of ten dollars."

The colored physicians, now licentiatees, were balloted for as members of the Society, were rejected, and were thus excluded from all share in the Society's "consideration and promotion of all subjects connected with medicine," &c. But, it would appear that such consideration and promotion is a dead letter, so far as this chartered



"Society" is concerned. Here, then, comes into play a wheel within a wheel. The medical practitioners of the District many years ago organized a voluntary Society, known as the Medical Association of the District of Columbia, its members apparently being the same as those of the previously-mentioned body corporate designated as the Medical Society of the District of Columbia. The Committee put it in this way:—

"By a supplementary process of metamorphosis, the 'medical society' changes itself into what is called a 'medical association,' with the same officers, but subject to a series of 'regulations' through which certain restrictions are established, plainly inconsistent with the charter, which, is the origin at once of the society and of the association. By these 'regulations' the members of the association are 'members or licentiates of the medical society,' who, 'having produced satisfactory evidence of qualification,' receive on ballots the vote of a majority of the members present, and, on election, subscribe the 'regulations' of the association.

"Thus is membership of the association twice guarded: First, the candidate must be a member or licentiate of the 'society'; secondly, being such, he must besides be chosen by a majority of the 'association.'"

The writer of the newspaper article, criticizing the Committee's report, says the above statement is incorrect, in so far that the officers of the "Society" are not the same with those of the "association." Say the committee:—

"Among the 'regulations' of the 'association' are two, deserving special attention from their inconsistency with the original charter. The first is the tariff of fees, when the charter expressly declares that 'nothing herein contained shall authorize said corporation in any wise \* \* \* to establish or fix a tariff of charges or fees, or to interfere in any way with charges or fees for medical attendance.' The second is the notable article that 'no member of this association shall consult with or meet in a professional way any resident practitioner of this District, who is not a member thereof, after said practitioner shall have resided six months in said District,' and this in the face of the charter, which declares, first, that 'nothing herein contained shall authorize said corporation in anywise to regulate the practice of medical or surgical attendance;' and secondly, that

'the by-laws, rules and regulations shall in their application and operation be exclusively confined to said society as a society or body corporate, and not to its members individually, when not acting in a corporate character.' Obviously, on the face, these 'regulations' are inconsistent with the charter of the 'society,' out of which the 'association' is derived. The attempt through this supplementary 'association' to accomplish what is forbidden to the 'society' is a plain evasion, which is a characteristic cover for the unworthy incidents which have occurred.

"By the act of Congress to which both society and association are traced there is no sanction for any exclusion on account of color, and all by-laws and regulations of fees or attendance are forbidden."

Whatever may be the exact relation of the voluntary "association" to the chartered "society," between the two the action of the members composing them seems to have brought about the situation set forth by the following facts adduced by the Congressional committee.

"Dr. Augusta, formerly an army surgeon and brevet lieutenant colonel, states that members of the medical society have repeatedly refused to consult with him, alleging as a reason that the laws of the society prohibited them from doing so. He then relates that in June, 1868, while in attendance upon a patient, the family desired that Dr. Garnett should be summoned. The messenger who went for him reported that he was out of town, but that Dr. Drinkard, who was in charge of his practice, said that he could not consult with Dr. Augusta, as the latter 'did not belong to his society,' but that he would take the case, which proposition was declined by the family, and Dr. Bliss, well known for his liberal nature, was called in, who consulted with Dr. Augusta, the society to the contrary notwithstanding. Dr. Augusta adds:—Dr. Garnett 'has taken two of my patients while I was attending them, and without any notice to me, except that at my next visit I was informed that Dr. Garnett was attending.' Another practitioner said of Dr. Augusta that he believed the latter was a good doctor, and he would have no objection to consult with him, but the rules of his society did not allow it. On this Dr. Augusta properly remarks:—

"Now you will see that all three of these gentlemen refused to consult with me, on the ground that I was not a member

of their society, while at the same time, when I have taken steps to become a member, they, with others, use extraordinary means to defeat my election and succeed in their object.'

"Dr. Purvis, one of the proscribed on account of color, relates an experience similar to that of Dr. Augusta. He was called suddenly to a patient, when, owing to the fright from sudden illness, messengers were sent to Drs. Lovejoy, Miller, and Norris. 'The patient,' he says, 'properly belonged to me; but when I ascertained that other physicians had been sent for, I waited to hold consultation with them. They arrived in a little while, but, to my surprise, excepting Dr. Norris, they would have nothing whatever to do with me.' And he then adds:—'It is not an uncommon experience of mine to have physicians take my patients, they knowing I had not been dismissed, thus doing me direct injury.' This testimony is in entire harmony with that of Dr. Augusta.

"Dr. Tucker, another of the proscribed on account of color, after testifying to the refusal 'to meet in consultation, thus subjecting physicians of color to great disabilities,' proceeds to mention three instances where members of the society had declined to go into consultation with him, one of them saying that 'it would be impossible to call in consultation, as the association would impose a fine upon him for so doing.'

"Such is the evidence before the committee, leaving no question of the damage done to these colored practitioners. But it must not be understood that all the members of the society follow the proscriptive rule. Some depart from it clandestinely—others openly. Some bravely challenge the censure of the society, while they perform simple professional duty.

"There is a further loss of educational opportunities produced by this proscription. If such opportunities are of value; if they are not entirely useless, then should they be extended generously to all practitioners who come within the condition of fitness. An exclusion on account of color is a limitation of medical education, which is the more unjust when it is considered how large a portion of the population here belongs to the proscribed race. In this aspect the conduct of the medical society is open to additional reprobation.

"From what has appeared before the committee, three things are in evidence:—

"1. That medical practitioners, above criticism in every respect, are refused admission to the society solely on account of color.

"2. That members of the society refuse to consult with medical practitioners, thus excluded on account of color to the serious detriment of such practitioners.

"3. That medical practitioners are now shut out from educational opportunities on account of color."

It strikes us that the allegation on the part of the "association" that its meetings were for social reunion, is hardly a sufficient excuse for the disabilities in the matters of consultation and medical improvement inflicted on the colored licentiates of the present "society." The committee tell us that they delayed action in order to give recalcitrant gentlemen time to alter their regulations; and we think we are keeping within bounds when we express the opinion that the rules or by-laws of the "association" might have been suspended to the extent of allowing consultations with the colored Doctors, so long as the latter should comport themselves like true physicians. Furthermore, in a profession so cosmopolitan as medicine, we hardly see how participation in the benefits of scientific discussion could have been consistently denied the licensed practitioners in question.

In following out this analysis, we have derived the impression that those composing the majority of the incorporate "society," and also the majority of the voluntary "association," have pursued a Bourbon policy, which is likely to prove disastrous to both organizations.

"The committee, for the present, content themselves with reporting a bill to repeal the original charter, which, according to its terms, Congress may 'at any time alter, amend or annul at pleasure.' \*\*\*

INSUBORDINATION OF THE NAVAL STAFF.—In view of the comparative uncertainty attending the question of naval discipline, especially as concerns the relative position of the medical staff, it will be gratifying to our readers to learn that at last a fixed point of departure for all future arguments has been established, and that the *deus ex machina* to whom all allegiance is due, and from whom all power and authority emanate, has deigned to display himself to the admiring gaze of subordinate mortals. It appears that even the supreme dignity of the Practical Business Man has its ascending grades, and that the very essence and

sublimation thereof centres in the person of a Mr. George W. Blunt, to whom the Secretary of the Navy and the awful potentates of "The Line" bear the relation of titular vicars; to whom is due the fealty of men in general, and of medical men in particular, and upon whose permissive fiat all congressional action must depend.

In reply to the mercantile memorial against conferring rank upon the naval staff, to which we called attention in our issue of the 8th inst., certain gentlemen representing the interests of the staff, addressed to the signers of that enlightened document, and among them to Mr. Blunt, the following courteous letter:—

"DEC. 22.—To George W. Blunt, Esq., New York: Sir,—The above memorial, signed, under the date of November 15th, 1869, by yourself and fifty-three other distinguished and influential citizens of New York, has been presented to the Congress of the United States. Your signature, and that of the other gentlemen associated with you, must have been given under great misapprehension of the facts, which are, that in every plan and scheme of staff rank which we have ever presented, the superior rank and authority of commanding officers have been carefully protected, as essential to that discipline which is as much desired by staff officers as by the other half of the navy—facts well known to every officer in the service and to the Naval Committees of Congress.

"We make this correction in the confidence that you will deem it proper, either to withdraw your name from the memorial, or to inform us on whose authority you have made the statements contained in it, which are so injurious to us, and to which you have, under obvious misapprehension, given the sanction of your honorable name.

"We are, respectfully, your obedient servants,  
Surgeon GEO. CLYMER,

And other Staff Officers of the Navy.

To this letter was made a rejoinder which, if it were to be judged by the rules governing correspondence between ordinary gentlemen, might seem rude and pretentious, but which, coming from a person of so much importance, and addressed to such inferior beings as naval surgeons, is, of course, not amenable to the usual standard of criticism. The Italics in the subjoined copy are ours:—

NEW YORK, Jan. 12.—Gentlemen,—I have received your circular, with the memorial addressed to Congress, in relation to the

bill before that body as to the rank of the staff of the navy, in which you ask me to withdraw my name, or give up that of the author of the document. Denying your right to make such a demand upon me as an infringement of my liberty of free action, I will say that I took a part in getting it up on information from one of the officers of the navy of the highest personal and professional standing; that I believed in the necessity of the memorial then, and do now. Had any doubt existed in my mind as to the propriety of my action, it would have been dispelled on the receipt of your memorial, as in my view the *sentiments of insubordination* conveyed in the demand made on the signers of the memorial, show the necessity of great caution on the part of Congress in legislating on this subject.

"Respectfully yours,

GEO. W. BLUNT."

"Surgeon Geo. Clymer and others, U.S.N."

We regret to add that this ultimatum was not received with that reverential humility to which it was entitled, but that the recipient thereof carried presumptuousness to the point of inditing a response, which we append with tremulous consciousness of its enormity:—

"WASHINGTON, D. C., Jan. 15.—Sir,—In answer to your note of the 12th inst., acknowledging the receipt of a circular, dated the 22d ult., signed by myself and many other staff officers of the navy, I have to remind you that our circular was a reply to a memorial to Congress, hostile to the interests of the Naval Staff Corps, bearing the names of yourself and other influential citizens of New York, and containing serious errors of statement in relation to us.

"Presuming these erroneous statements to have been made under misapprehension, we referred, in disproof of them, to the records of all the plans of rank ever proposed by the staff officers, as known throughout the service, and to the Committees of Congress, before whom the plans had been laid.

"In making these references, we supposed that we were doing a kindness for those who had been led into error, by giving them the information which would enable them to correct and acknowledge it.

"In this light the circular appears to have been regarded by all from whom we have received replies, except yourself; and you characterize our correction of your errors as insubordinate.

"The circular was courteous, and could

have been in no way insubordinate, as we owed you no submission.

"The fact that you avow yourself as partially the author of the memorial, and decline to name any better informed authority for its misstatements, does not alter its nature; and we are willing to leave you with the responsibility you have assumed.

"It is due to our cause, and to truth, that we publish your discourteous note, with this reply, in connection with the correction we have already made of the misstatements for which you assume responsibility. Respectfully, GEO. CLYMER,

Surgeon U. S. Navy,  
for himself and for such of his associates as he has had the opportunity to consult."

"To Geo. W. BLUNT, Esq., New York."

If, as is thus decided on the highest authority, those members of our profession who, in addition to their scientific degrees, hold commissions as officers in the navy, should manifest silent subordination to the decrees of Mr. Blunt, who lives at ease ashore, it is evident, *a fortiori*, that we mere medical land-lubbers must owe to him still more abject submission; and we therefore hasten to acknowledge our subordination, of which we were previously unaware, and impress upon our professional readers a solemn sense of their duty under this new order of things.—*New York Med. Gazette*, Jan. 29.

**THE WELSH FASTING GIRL.**—The drama of the Welsh fasting girl, which was regarded in the first instance by all reasonable persons as a farce, has ended tragically. Four nurses from Guy's Hospital who were sent to watch her, said that she literally fasted for eight days, at the end of which time she died. The watching began on December 9th, and was terminated by the death of the girl at 3 P. M., on December 17th. On December 11th she is reported to have been not looking so well, but up to the 14th she is said to have amused herself with reading and to have appeared cheerful. She slept at intervals; her cheeks appeared flushed. On December 11th the nurses observed stains of excrement on the girl's dress. On the 13th she is reported to have passed a large quantity of urine, and on the 14th and 15th a smaller quantity. For three days before her death her extremities were cold, and during the last two days she was restless, throwing off the bed clothes, and tossing her arms about. She asked for no food, and made no confession of deceit. No attempt was made to force food upon her, but it seems she was offered it by her uncle

on the day of her death. "She made no reply, but appeared to go off into a fit." On the same day, when the child was sinking, her father refused to allow Mr. Davies, the Surgeon who attended her, to give her food, but afterwards said that he might do so. Mr. Davies did not, however, "as it was too late." An inquiry is being held by the local coroner, and a *post-mortem* examination has been made by Messrs. Thomas and Phillips. At the time of our going to press the inquest is proceeding, but we extract the following report of Mr. Thomas's evidence given at the first day's sitting from the *Western Mail* of December 22d:—

"Mr. James Thomas, Surgeon, Newcastle-Emlyn, was the next witness, and said: On Monday, in conjunction with Mr. Phillips, in the presence of Dr. Lewis and other gentlemen, I examined the body of Sarah Jacobs, said to be about 12 years and 6 months of age. It measured about 54 inches, was plump and well formed, and showed indications of puberty. I opened the head and found the membranes of the brain considerably injected with blood, which in all probability happened a few hours before death. The substance was not very vascular, but perfectly healthy and of proper consistence, and there was not the slightest difference between the sides of the brain. An incision was then made from the top of the chest down to the lower part of the body, which displayed a fine layer of fat, from half an inch to an inch thick, there being fat all through the incision. The chest—lungs, heart, and great vessels—were perfectly sound and healthy, containing very little blood. I then came to the most important part of the inquiry—that of the alimentary canal, and my first observation was that there was not the slightest obstruction from the mouth to the termination of the gut, which included about 33 feet. The stomach was opened, and it contained about three teaspoonfuls of semi-gelatinous fluid, as if it had been mixed with a little bile, having a slight acid reaction with litmus paper. The whole of the small and large intestines were then laid open, and the small ones were empty, but in the colon and rectum there was about half a pound of excrement in a hard state (which was produced for the jury to examine, if necessary); the liver was healthy, with the gall-bladder considerably distended with bile, the kidneys and spleen perfectly sound, and the urinary bladder perfectly healthy—in fact, as far as eyes could see, no malformation or disease, judging from the healthy appearance of the organs. My

theory is that death resulted from want of nutriment and sustenance."

It would be a departure from custom to comment at length on this case until the public inquiry has terminated. All we can say at present is that it is impossible not to regard it with indignation. The poor hysterical child who is dead was not the chief person to blame. The facts of her having breathed for two years and passed urine prove undeniably that she must have taken food. That she denied the fact is only a common symptom of hysterical disease, and that she found persons in her father's house to humor her and assist her in the deceit is not surprising when it is remembered that she attracted sightseers who paid or made her presents. Those who are most to blame are the educated gentry and Professional persons in the neighborhood, who, instead of scouting the idea of anything but hysteria and fraud in the case, lent their aid, by talking and writing in a half-credulous fashion, in spreading the girl's reputation as a living wonder. If a physician had in the first instance told the parents that simulating fasting was a well-known phase of hysteria, and that the proper treatment was to introduce a tube into the stomach or rectum, and to feed her thereby, and had insisted on seeing his prescription carried into effect, or, in case of opposition, had appealed for power to a magistrate, the poor girl's life might have been saved. Instead of this we have had silly people kept on the *qui vive* for two years by sensational paragraphs in Medical and other papers—then "a committee formed to investigate the case," and nurses sent down from a London Hospital to watch her, with what result has been seen. The whole thing is as great a national disgrace as it would be to try a woman for witchcraft by the ordeal of drowning.—*Medical Times and Gazette*.

#### SUCCESSFUL EXTIRPATION OF ONE KIDNEY.

—Mr. Spencer Wells, in a letter to the *London Medical Times and Gazette*, says:—

I have just received a letter from Prof. Wagner, of Königsberg (so well known here by Mr. Holmes's excellent translation of his work on the healing process after the resection of bones and joints, published by the New Sydenham Society), and I think the following extract will be read with great interest:—

"As I passed through Heidelberg, I saw a patient of Simon's whose case will interest you extremely. A provincial Surgeon had performed ovariectomy for her; and, on

account of inseparable adhesions, had removed both ovaries and the uterus as far as the neck. The patient recovered. It appeared, however, that the operator had also injured the right ureter, for a urethral fistula formed in the cicatrix in the abdominal wall. This led to the patient going to Simon. After several unsuccessful attempts to cure the fistula, Simon at last *extirpated the right kidney*. He went in from the lumbar region, shelled the kidney out of its capsule, tied *en masse*, and cut it away. I saw the patient cured, and going about with the fistula also cured. The ligature threads had not come away. Simon now proposes extirpation of a kidney for such diseases as echinococcus, abscess, hydronephrosis, and renal calculi."

I may add that I have seen a healthy kidney, inseparably connected with a fibrocystic tumor of the uterus, removed with the tumor; and, although the patient died on the third day, there was not one symptom which could be referred to the loss of the kidney. The urine was normal in quantity and character, and there was no sign of uræmia.

I have also published cases which show that cysts of the kidney may be very successfully treated by tapping and drainage, and have joined in advising nephrotomy in some cases of renal calculi. When Simon publishes his case of extirpation of the kidney, he will no doubt discuss the principle of this operation, and we shall be glad to have a broad distinction drawn between cases in which disease of one kidney is killing a patient, and such a case as that of a urinary fistula where life is not threatened.

It may also be of some interest if I add that the lady from whom I removed a large fibroid uterus and both ovaries last summer, and of whose case I gave a short account in a paper on chloral in your number of October 2d, 1869, is not yet at all strong, and occasionally suffers from pain and sickness.

FROM the report of John W. Sawyer, M.D., Superintendent of the Butler Hospital for the Insane, Providence, R. I., we learn that there were in the Hospital, at the commencement of the year 1869, one hundred and fifty patients—seventy-five males and seventy-five females. During the year seventy-three have been admitted—forty-four males and twenty-nine females—making the whole number under treatment two hundred and twenty-three. Sixty-nine have been discharged—thirty-nine males and thirty females—leaving now in the house, one



hundred and fifty-four patients, of whom eighty are males and seventy-four females. Of those discharged, thirty-three had recovered, nineteen had improved, nine were unimproved and eight died. Four of the deaths were from exhaustion from chronic mania, one from valvular disease of the heart, one from phthisis, one from epilepsy and one from paralysis.

The patient who died from phthisis had recovered from his insanity several weeks before his death, but his physical condition was such that I was unwilling to insist upon his removal, and he was allowed to end his days here. The patient who died of heart disease was in the house only forty-eight hours. He expired suddenly, but not unexpectedly, as he attempted to rise from bed.

The statistics show that the operations of the Hospital have been attended with very gratifying success. The proportion of recoveries is large and the number of deaths unusually small, being the same as last year. There have been, within the year, several cases of severe bodily illness, but no prevalent physical disease, nor any serious accident.

**A DISLOCATION (BILATERAL) OF FIFTH CERVICAL VERTEBRA, SUCCESSFULLY REDUCED.** By W. H. WHITE, M.D., Springfield, Mass.—January 13th, I was called to see a son of T. J. S., who had received an injury while playing with a mate attending the same school. Upon inquiry, I found that he had received a severe blow upon the back of the neck from a playfellow during a game of "chase." He fell and remained there, insensible, until his teacher, missing him, found him in the yard, when she had him conveyed to his home. I was sent for immediately, and upon examination, found there was a dislocation of fifth cervical vertebra, with head thrown back, and permanently fixed, and face looking upwards. There was no paralysis, but the parts upon pressure were very sensitive. The posterior portion of neck showed deep depression, the anterior bulging out, size of half goose-egg, by forcing the "larynx" out of position. Swallowing somewhat difficult, and breathing somewhat labored.

The reduction was accomplished by seizing the head by chin and occiput (the patient being held in chair by the assistant) and all of my force used to draw head directly backwards, then upwards, and then forwards; the vertebra slipped in its normal position with an audible snap. He has

experienced no inconvenience since, save a small amount of soreness; in fact, the third day after the reduction, he was trying to show his little sister how he could stand upon his head.—*New York Medical Gazette*.

#### DEATHS FROM CHLOROFORM.

THE State of Massachusetts imposes a fine upon the party responsible whenever a train on a railroad neglects to come to a stop at the intersection of another railroad; half the proceeds to go to the informant. The legislature would do well to inflict a similar punishment upon the administrator in every instance when chloroform is given by inhalation. Half the sum thus accruing to the treasury might be appropriated to the building of that monument of black marble in commemoration of the victims of chloroform, which it has been proposed to erect over against the ether monument in the Public Garden of Boston.

*Death during the Administration of Chloroform by Sir James Y. Simpson.*—We learn from the *Pall Mall Gazette* that a young woman has died from the effects of chloroform at the hospital at Alloa, the administrator having been Sir James Y. Simpson. The profession will receive with much interest Sir James Y. Simpson's own version of the occurrence.—*London Lancet*, Feb. 12, 1870.

The *British Medical Journal* for Feb. 12 refers to the above occurrence thus:—

"A death has occurred, during the administration of chloroform, on the operating table at the Alloa Hospital. Sir James Y. Simpson administered the anæsthetic; Sir James, however, informs us that the symptoms shown render it doubtful whether the patient died from the effects of the chloroform. We hope to be able to give full details next week."

*Death from Chloroform; Fatty Degeneration of the Heart.* By J. F. MINER, M.D.—The following case of apparent death from chloroform is of value, in a statistical point of view at least, and has some features of interest connected with the general questions of, to whom, and under what circumstances, is it safe and proper to administer chloroform.

Oct. 20.—E. B., aged about 40, received injury in coupling cars, the right hand being crushed between the car bumpers. He was brought into my office, and, upon examination, was told what was before quite apparent to him, that amputation of the forearm would be necessary.



He requested chloroform to be given, and I commenced its administration, while my private students arranged for the operation. The chloroform was given by dropping it upon a napkin and holding it at sufficient distance to allow ample atmospheric air. After breathing it for a few minutes he became talkative, and finally considerably excited, requiring restraint. He soon had a condition of rigidity of the muscular system, drawing back the head, as in partial convulsion. This condition attracted my attention, and caused me to withdraw the chloroform, though he had the second before talked loudly and profanely, and did not appear enough under its influence for me to think of permanently discontinuing it. His appearance was now peculiar and cannot be described by words. I noticed that there was something in his respiration and general condition which I had never before observed in patients inhaling the vapor of chloroform. I had merely time to say to my assistants his pulse is very weak, when I was obliged to finish my sentence by saying, it has stopped. Respiration ceased after one or two short inspiratory efforts, and my patient was dead.

Such is the brief history of what occurred before *post-mortem* examination, in which I was assisted by a number of my professional friends.

[An account of the autopsy is given, succeeded by the following—]

REMARKS.—The extreme fluidity of the blood, and the fact that both the right auricle and right ventricle were enormously distended, is, to say the least, peculiar—and affords much room for speculation. There was fatty muscular degeneration to an advanced degree, and yet it is very doubtful if this could have been detected by careful physical exploration, conducted at any time before the occurrence of the sad accident.

In most of the deaths from chloroform, where *post-mortem* examinations have been made, "fatty degeneration of the heart" is reported. This condition must be much more frequent than is generally supposed; and where there have been no signs or symptoms to indicate its existence, it cannot be discovered by manipulation or auscultation. —*Buffalo Medical Journal*, January, 1870.

[It follows, then, that chloroform is liable to kill in cases where there is no special reason to anticipate a fatal result.—Ed. B. M. & S. J.]

*Probable Death from Chloroform.*—Henry B., while intoxicated, fell in front of a R. R. Engine, which passed over his left leg below the knee, crushing and mangleing it completely and frightfully. This was about 6 o'clock, P. M. He was immediately taken to St. Francis Hospital, and Prof. Hamilton called to see him.

He found the man cold, wet, and unconscious—in fact, in a state of shock that can only be contemplated in connection with such an injury.

He was placed in a comfortable bed, stimulants (hot whiskey) and morphine were freely given, and external heat applied. Under these he promptly reacted, but an operation was deferred until the next morning.

The morning following, the patient was in as good condition as could be expected of one thus injured. Pulse of good volume, not much accelerated, and regular. He was placed upon the table, was in good spirits, and in every respect seemed in a condition to endure the operation. An assistant gave the chloroform after the usual method, but it was noticed that the anæsthetic effect was produced unusually quickly. In fact, the patient was anæsthetized almost instantly. The pulse became slow, of little volume and irregular; the breathing irregular and intermittent, being of a somewhat spasmodic character. The symptoms becoming more favorable, the operation was performed, the leg being amputated at above the knee. There being no room below, nor sufficient uninjured soft parts for flaps in disarticulating at the knee joint, the indications were plainly to amputate immediately above.

There was but little hemorrhage in the operation, nor had there been since the time of injury up to the time of and including the operation, enough hemorrhage to produce any great prostration.

Soon following the operation, the pulse began to fail, became weak, irregular, and intermittent, the breathing interrupted and spasmodic, with gasping. Artificial aid was used to facilitate the respiration but to little purpose, and the patient soon ceased entirely to breathe.

This person being a stranger and his habits of life unknown, there was uncertainty in giving an opinion on the cause of death. May he have been an habitual drunkard, and, as long as excitement was kept up by the free administration of stimulants, have reacted and manifested but little shock, while, when this prop gave way upon the table, the powers of the system rapidly succumbed; or is this another of the mysterious freaks of chloroform?

This is the first case of death that has occurred in Prof. H.'s practice in connection with the use of chloroform. In this instance, he thinks it had such a suspicious part in causing death, that he has resorted to his former practice of giving ether where an anæsthetic is called for. Experience would indicate that, of the two, ether is the safer. If so, have we not had enough unequivocal testimony of deaths from chloroform, to prompt us to the employment of a safer, if not a better anæsthetic?—*New York Medical Gazette*, Feb. 5, 1870.

A demon in gin, residing in Brooklyn, named Cassidy, has been arrested on suspicion of causing his wife's death; both husband and wife were confirmed sots, and frequently indulged in mutual knock-downs. On Wednesday last the wife became the victim of the most shocking brutality at his hands, and while suffering from the injuries which led to her death endeavored to shield him by telling the physicians that they were caused by accident. *She took chloroform to allay the pain, but had become so thoroughly exhausted by previous ill-treatment that the application taxed her fast-ebbing strength beyond the power of her feeble constitution, and all attempts to restore respiration proved futile, and the poor woman soon passed beyond the reach of the fiend whose crime she sought to shield.*—*Boston Post*, Feb. 21, 1870.

## Medical Miscellany.

**MASSACHUSETTS MEDICAL COLLEGE.**—The annual commencement for the conferring of medical degrees will take place at the Medical College on Wednesday, March 9th. The exercises will commence at 11½ o'clock, graduates reading selections from their dissertations. The degrees will then be conferred, and the exercises will conclude with an address by Rev. Dr. Peabody.

**THE CONSUMPTION OF TOBACCO.**—The *Gazeta Medica da Bahia* learns from the *Paris Figaro* that Asia produces annually 155,000 tons of tobacco; Europe, 141,000; America, 124,000; Africa, 12,000; Australia, 400. The annual consumption of the weed in France is, of snuff, 7,800 tons; of smoking tobacco, 18,441; of chewing tobacco, 756; of cigars of various brands, 3004 tons. The bulk of the snuff is equal to that of thirty pillars each of the size of the column of Vendôme; that of the smoking tobacco to a cube of the size of the Arch of Estrella; and the cigars if collected and placed point to point, would occupy a line 74,360 miles long, or three times the circumference of the globe. These data are published by an association which has been formed in Paris, and which contains 1200 active members. It is called the *Anti-tobacco League*.

**DR. G. C. S. CHOATE** has resigned his position of Superintendent of the State Lunatic Asylum at Taunton, much to the regret of the Trustees. The resignation does not take effect for some three months from this time. Dr. Choate, we are informed, goes to New York to practise in the special department in which he is so well versed. We are tempted to envy the metropolis so valuable an acquisition.

**PROSTITUTION IN ENGLAND.**—The Editor of the *London Medical Times and Gazette* says:—"We think it may be admitted on tolerably good evidence that the English policy, by which prostitutes have been left to their own devices, so long as they do not annoy their neighbors, has been less productive of injury than that which has endeavored to put prostitutes down with a strong hand. Comparing our policy with that of countries where prostitution is forcibly regulated, we have to ask two questions—namely, whether this forcible regulation has resulted in less sexual immorality, and whether it is apparent that, on the whole, syphilis, as a disease infecting the national health, is less rampant than it now is amongst ourselves. We confess that, so far as we have been able to study the subject by the evidence furnished us, we are far from satisfied that this is the case. We are now speaking not of the military but of the civil population of these countries."

At the last meeting of the New York State Medical Society, Wm. Warren Greene, M.D., of Portland, was elected an Honorary Member.

**BILIARY CALCULI.**—Dr. Barclay, of Leicester, thinks that chloroform is an admirable solvent of biliary calculi. He gives it in doses of two or

three drops three or four times a day.—*Dublin Medical Press and Circular*.

**CORRECTION.**—An ophthalmic friend has pointed out to us that his confrere Mr. Bader did not make the statement quoted by us in our last issue—that "no accidents of any kind have occurred with the nitrous oxide gas or the bichloride of methylene"—as a general proposition; but only as applicable to the Eye Department of Guy's Hospital. If Mr. B. had said none of the anesthetics used had been fatal, the expression would have been free from the ambiguity, which was increased by his specifying the Hospital as the subject of another remark further on in the paragraph which was commenced by the statement in question. By leniency of construction we accord the correction.

**TO CORRESPONDENTS.**—Communications accepted:—Vaccination—Article by another "Innominate"—Remarkable Case of Injury of the Brain.

**PAMPHLETS RECEIVED.**—Sixteenth Report upon the Registration of Births, Marriages and Deaths in the State of Rhode Island, for the year ending Dec. 31, 1868. Prepared under the direction of John R. Bartlett, Secretary of State. By Edward T. Caswell, M.D. Pp. 84.

**DIED.**—In Philadelphia, March 2d, Dr. Thomas Dilard, Surgeon U. S. N., aged 70.

**Deaths in sixteen Cities and Towns of Massachusetts for the week ending Feb. 26, 1870.**

Cities and towns.	Number of deaths in each place.	PREVALENT DISEASES.	
		Consumption.	Febrile.
Boston . . . . .	112	24	5
Charlestown . . .	13	4	2
Worcester . . . .	16	0	4
Lowell . . . . .	20	3	4
Milford . . . . .	6	2	2
Chelsea . . . . .	8	0	1
Cambridge . . .	14	3	2
Salem . . . . .	7	1	2
Lawrence . . . .	9	2	0
Springfield . . .	13	4	3
Lynn . . . . .	12	5	0
Pittsfield . . . .	2	0	1
Gloucester . . . .	10	1	0
Fitchburg . . . .	4	1	2
Newburyport . .	2	0	0
Fall River . . . .	12	1	1
	260	51	28

Five deaths from smallpox are reported; four in Boston and one in Worcester. Twelve deaths from measles reported; of which number five were in Lowell and four in Boston. Four deaths from scarlet fever reported; of which number two were in Boston. Six deaths from typhoid fever in all the above-named places.

GEORGE DERRY, M.D.,  
Secretary of State Board of Health.

**DEATHS IN BOSTON** for the week ending February 26, 112. Males, 41—Females, 68.—Accident, 1—apoplexy, 1—inflammation of the bowels, 2—congestion of the brain, 1—disease of the brain, 2—inflammation of the brain, 1—bronchitis, 3—cancer, 1—consumption, 24—convulsions, 5—cyanosis, 1—debility, 6—diphtheria, 3—dropsy, 3—dropsy of the brain, 2—drowned, 2—epilepsy, 1—erysipelas, 1—typhoid fever, 2—scarlet fever, 2—fistula, 1—gastritis, 2—disease of the heart, 5—interperence, 1—disease of the kidneys, 1—congestion of the lungs, 3—inflammation of the lungs, 2—marasmus, 4—measles, 4—neuralgia of heart, 1—old age, 3—paralysis, 2—peritonitis, 1—pleurisy, 1—premature birth, 3—puerperal disease, 2—rheumatism, 1—smallpox, 4—unknown, 6—whooping cough, 1.

Under 5 years of age, 37—between 5 and 20 years, 9—between 20 and 40 years, 31—between 40 and 60 years, 17—above 60 years, 18. Born in the United States, 65—Ireland, 32—other places, 13.